

SUBMIT IN DUPLICATE

Kentucky Board of Pharmacy
Continuing Education Program Approval Form

23 MILLCREEK PARK, FRANKFORT KY 40601-9230
(502) 573-1580 Fax (502) 573-1582

☐ Group Request or ☐ Individual Request Date _____
☐ Attendance at Program
☐ Presentation of Program

Title/Topic _____

Name of the Provider _____

Address _____

Address Name Sponsor _____
(Responsible for Program Offering)

Name of Individual / Group Submitting for Approval _____

Address _____ Home Phone _____
Business Phone _____

General Purpose/Objective of Program* _____

Brief Summary or Outline of Program* See Attachment: a copy of the Moderator's guide.
(Enclose Brochure or List Topic(s) Schedule(s))

Faculty / Presenters*
(Name and Qualifications) _____

Program Dates	CEU(s)	Contact Hours	Site
Mode / Method of Presentation:			
Live Presentation _____ (Minutes)	Video _____ (Minutes)	Discussion _____ (Minutes)	Other _____ (Specify) (Minutes)

Anticipated Audience: _____
(Association, Organization, Staff, Health Discipline, Etc.)

Composite Evaluation: (Not necessary for individuals) MUST be submitted with this form for completed programs or within ten days of presentation.
Any omission or delay may result in denial or reduced approval.
Sample forms are available from the Board office.

**Remarks may be included on back of form.*

FOR OFFICE USE ONLY

Approved _____ Disapproved _____ CEU(s) Awarded _____ ID No. _____

Date

Pharmacy Education Coordinator